

Chronic Care Management Focus Group with Providers

On March 3, 2006, a focus group was held with several health care providers and a non-practitioner executive of a clinic group from across Washington State. One provider participated by telephone and the other seven were present in Seattle. Participants were recruited for the focus group based on their previous participation in chronic disease collaboratives, with experience in the chronic care model ranging from three to six years. The group was facilitated by Jan Norman of the Department of Health Chronic Disease program, and Alice Lind, Care Coordination Office Chief of Health and Recovery Services Administration (HRSA). Alison Robbins and Veronica Foster-Jones, of the HRSA Disease Management (DM) program, also participated.

The focus group began with introductions and the purpose of the focus group, which was to inform HRSA's decision-making process as the current disease management program contracts expire in June. Information gathered at this session will contribute to a new model of chronic care management for disabled Medicaid clients. Staff presented a brief overview of the current Disease Management program in Washington, and the recently signed Executive Order on Chronic Care from Governor Gregoire. The focus group discussion followed.

Providers were asked about whether their practices limit the numbers of Medicaid enrollees. With the exception of the Federally Qualified Health Center, all of the providers had limits to the numbers or percent of Medicaid enrollees. One practice limits their enrollment to 13%; another cited that only 51 of 141 providers are currently open to Medicaid. There are limits by specialty as well, with current problems referring to pain specialists and urology.

The providers were asked to describe the challenges of taking care of disabled or chronically ill Medicaid clients. The following issues were mentioned:

- Medicaid clients have a higher than average visit rate. Providers know they will be complex visits, so they schedule long visits, frequently the client does not show up. So, for the next visit, the provider schedules a short visit and the client does show up and needs more time.
- Certain characteristics were thought to be common among Medicaid clients: higher than average prescription drug use; lack of access to old medical records; lack of concern about their chronic illness; lack of personal resources, e.g. transportation and difficulty taking care of their own health.
- The complexity of the clients' conditions make them hard for nurse practitioners and family practice physicians to manage.
- Mental health and social problems. One provider said, "If I had a magic wand, I would get help with mental health." Many providers agreed that the lack of access to mental health is a problem, so providers need counselors or psychiatric nurses to help manage the behavioral issues. We (at the state) have created barriers to integrating mental health and primary care.

- Most clinics have limitations in resources for the acuity level of clients. Rarely, an RN is available to do teaching and follow up. Primary care MD's don't have counseling services for nutrition and behavioral change.
- Access to dental care.
- Treatment for chronic pain is hard to access. The state could save money on diagnostic work-up for pain by providing proactive management.
- Limitation in access to primary care in some areas of the state results in multiple hospital admits. Some community clinics lose continuity of care when patients are admitted to hospital.
- Private offices are not prepared to offer all the services to adequately meet the needs, given the current delivery structure. Mental health and chronic pain are 2 areas of insufficient resources in the community to meet the need. Community Health Centers do have the additional services for referral to mental health.

The next question was: What could DSHS do to support you in taking care of Medicaid clients with chronic illness? The following ideas were shared:

- Chronic care management should be an approach shared by all state agencies and managed care plans under contract to state agencies for health care. The interventions should be applied regardless of payor. The current fragmentation does not help; one provider called it a "non-sense fit." Many health carriers or state insurers cover a small number of clients in each provider's practice. Every insurer has a different approach, different forms, etc., and the provider just ignores them. Evidence based care and administrative simplification should be driven from the top and synchronized.
- Providers are reluctant to fill out multiple pages of paperwork for the disease management company or health plan.
- Providers need to know the goals of care management, then allow flexibility in the way they provide it, especially for less organized systems.
- One provider said that in its current form, disease management is useless to MD's: "Primary care is a team sport." Providers asked for a regional or local solution where the DM nurse can become part of the system of delivering care.
- Providers agreed that being paid a certain amount of money per enrollee might work, as long as it was not limited to certain diseases. It was considered more important to target care management based on the clients' ability to self-manage.
- One provider shared that his brother-in-law was helped by a McKesson nurse, so he knows it can help. But, he is still wondering if that is the best way to spend state resources.
- One provider speculated that there must be a concentration of DSHS clients in organized delivery systems that have electronic medical record, e.g. It was pointed out that when the state's Disease Management program was first started, the infrastructure did not exist to support chronic care management. Now, counties have the infrastructure, building on the work of the collaboratives, which presents a new opportunity. Providers did not feel that more work on evidence based guidelines was needed, it would be fine to piggyback on nationally adopted standards. The focus should be on self management support.

- The providers described the ideal assistance of a nurse or other care manager in this way: “You need someone you can build a trusting relationship with.” “You need to be able to communicate with them, and get communication back.” The person’s role needs to be integrated into care. One person working with one practice, a regional approach, or at least one assigned person to the provider practice. The care manager salary could be paid for by all difference sources. “Having a nurse inside the system that sits in the clinic one day per week, trained on our computer,” so he/she can enter information right into the EMR.
- Both the high touch and high tech approaches are important. Patients tend to be much more compliant with telephonic intervention if they have met the nurse face to face.
- Other ideas included the “district nurse model” from England – could the health department or home health service help? Also the notion that the care manager does not have to be nurse – a lay health worker, someone who provides crisis management support, or a culturally similar person might work better at times.

We described the models used in Indiana and North Carolina as models to consider from other states. In both, Medicaid clients are enrolled in a Primary Care Case Management program. The physician receives a monthly fee for case management (very small). In North Carolina, there is an additional layer of a PCCM Network (covers many counties), and it gets a separate monthly fee for administrative functions. In Indiana, these functions are performed by the state or by contracted nurse organizations. We asked whether certain administrative functions provided by the state to improve chronic care management would be helpful.

- Assign clients and give a roster to physicians of who are their Medicaid clients? Providers thought this was a good idea. \$2.50 pmpm is sufficient if it covers all SSI clients. Allow flexibility in how the pmpm is used to meet the extraordinary demands of these patients.
- Provide data on use of medical services? First the providers said this was not needed, but they did agree that data on ER use and hospitalization would be good if timely.
- Provide a nurse consultation phone line? Providers do not feel this helps them. It interferes with practice as the information never gets back to them.
- Nurse education support by telephone and in person? This is the core of what is needed, especially if in person, and if the provider has a trusting relationship with the nurse.
- Nurse case management for coordination of care? As above, this is critical. The case manager is needed to help sort out issues with the patient, and to address behavioral issues. Behavioral health consult for the PCP would also help.
- Standard forms and tools to use for assessment, care plans? Not needed, very retro – EMR takes the place of this. However, there was a request for the Infrastructure Advisory Board to prioritize work around EMR, common registry. Providers would like common data reports for all state paid patients. Once we have our approach down, we need to consolidate with state payors quickly.

Last, we asked whether provider would support a system of paying a bonus for quality improvement, such as a “Pay for Performance” program, or Bridges to Excellence as one model. The providers were unanimous in saying they would not support PFP programs for this population. This is not the priority, it can wait a few years until everyone is together. Pay for participation in the program, not for outcomes: these clients are much sicker than average. It might be acceptable to offer a financial reward for infrastructure, such as having a registry place, or we could make this a requirement for participating in the chronic care effort.

Participants:

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